

OFFICE OF LEGISLATIVE RESEARCH
PUBLIC ACT SUMMARY



PA 11-242—sHB 6618

Public Health Committee

Planning and Development Committee

Finance, Revenue and Bonding Committee

**AN ACT CONCERNING VARIOUS REVISIONS TO PUBLIC HEALTH
RELATED STATUTES**

SUMMARY: This act makes numerous substantive and minor changes to Department of Public Health (DPH)-related statutes and programs. These changes address:

1. health professional licensing, discipline, continuing education, and rehabilitation;
2. vital statistics;
3. foundlings;
4. health and child care facilities including child day care, youth camps, school-based health centers, maternity homes, nursing homes, residential care homes, and hospitals;
5. health care services covering sexually transmitted diseases and partner therapy, needle exchange, and vaccines;
6. stem cell peer review and advisory committees;
7. reportable diseases and emergency illnesses and conditions;
8. clinical laboratories;
9. certificates of need;
10. opiate dependency treatment;
11. breast and cervical cancer;
12. emergency medical services;
13. bone densitometry;
14. dead bodies for medical study;
15. drug screening;
16. fluoroscopy;
17. telepharmacy;
18. residential unit leasing;
19. long term care strategic planning;
20. child abuse and neglect information disclosure;
21. community-based provider licensing;
22. bottled water and various water resources-related issues;
23. funeral service businesses;
24. health information technology;
25. patient access to medical test results; and
26. criminal history and patient abuse background searches.

It also eliminates various reporting requirements and makes technical and conforming changes.

OLR PUBLIC ACT SUMMARY

EFFECTIVE DATE: Various, see below.

§ 1 — HEALTH PRACTITIONER DISCIPLINE

The act allows a health practitioner licensing board or commission or DPH to take disciplinary action against a practitioner's license or permit if the individual was subject to disciplinary action, similar to action that can be taken in Connecticut, by an authorized professional disciplinary agency of any state, the District of Columbia, a U.S. possession or territory, or a foreign country. The board, commission, or DPH can rely on the findings and conclusions made by that other jurisdiction's agency in taking the disciplinary action.

EFFECTIVE DATE: July 1, 2011

§ 2 — PORTABLE OXYGEN SOURCES

The law allows a hospital to designate any licensed health care provider and any certified ultrasound or nuclear medicine technician (the act changes this title to technologist) to perform certain oxygen-related patient care activities in a hospital. The act specifies that this should not be construed to prohibit a hospital from designating individuals who are authorized to transport a patient with a portable oxygen source.

EFFECTIVE DATE: July 1, 2011

§ 3 — RESTRICTING, SUSPENDING, OR LIMITING LICENSES OR PERMITS

The act allows DPH to restrict, suspend, or otherwise limit the license or permit of a health professional according to an interim consent order entered during the individual's investigation.

EFFECTIVE DATE: July 1, 2011

§§ 4 & 5 — FOUNDLINGS

The act defines "foundling" as (1) a child of unknown parents or (2) an infant voluntarily surrendered in a hospital. Under prior law, if the foundling is later identified and a birth certificate is obtained, the birth certificate is substituted for the report of foundling. The act exempts infants voluntarily surrendered at hospitals from this requirement.

It also requires a hospital to prepare a foundling report for any infant voluntarily surrendered in the facility. If a birth certificate has already been filed in the state birth registry, the report must substitute for the original birth certificate, which must be sealed and confidentially filed with DPH. The original birth certificate cannot be released except on a court order.

EFFECTIVE DATE: October 1, 2011

§§ 6 & 7 — REGISTRARS OF VITAL STATISTICS

The act requires a town's newly elected or appointed registrar of vital

OLR PUBLIC ACT SUMMARY

statistics to notify the DPH commissioner in writing within 10 days of taking office. The town's first selectman or chief elected official must notify DPH of any vacancy within 10 days after it occurs.

The act requires the registrar of vital statistics to notify DPH in writing within 10 days after appointing an assistant registrar or a vacancy occurring.
EFFECTIVE Date: October 1, 2011

§ 8 — VITAL RECORDS ACCESS

The act adds conservators of the person appointed for the person to those who can obtain a certified copy of birth and fetal death records and certificates less than 100 years old. It also removes title examiners' ability to obtain such records.
EFFECTIVE DATE: October 1, 2011

§§ 9 & 10 — EXPEDITED PARTNER THERAPY

The act allows a prescribing practitioner who diagnoses a patient as having a sexually transmitted chlamydia or gonorrhea infection to prescribe and dispense oral antibiotics to the (1) patient and (2) patient's partner or partners. It allows the practitioner to do so without physically examining the patient's partner or partners. A practitioner who prescribes or dispenses antibiotics in this manner does not violate the practitioner's standard of care. The law defines a "prescribing practitioner" as a physician, dentist, podiatrist, optometrist, physician assistant, advanced practice registered nurse (APRN), nurse-midwife, or veterinarian licensed in Connecticut to prescribe medicine within his or her scope of practice (CGS § 20-14c).

The act allows the DPH commissioner, in consultation with the Department of Consumer Protection (DCP) commissioner, to adopt regulations to implement this provision.

It also clarifies the authority of municipal health departments, state facilities, physicians, and public or private hospitals and clinics to examine or treat a minor for venereal disease. Existing law allows physicians and facilities to examine and provide such treatment.

EFFECTIVE DATE: October 1, 2011

§ 11 — NEEDLE AND SYRINGE EXCHANGE PROGRAM

The act updates DPH's needle and syringe exchange program by specifying that DPH establish programs in the three cities having the highest number of human immunodeficiency virus (HIV) infections among injection drug users, rather than in their health departments. Previously, the standard was the highest number of AIDS cases among intravenous drug users. The act specifies that the program provides for free and confidential, rather than anonymous, exchanges of needles and syringes. By law, first-time applicants to an exchange program receive an initial packet of 30 needles and syringes. The act eliminates a provision that the program assure, through program-developed and DPH-approved protocols, that a person receive only one such initial packet over the program's

life.

The act requires any organization conducting the exchange program, rather than only the local health department, to report on the program's effectiveness to DPH. DPH must establish requirements for programs to monitor (1) return rates of distributed needles and syringes, (2) program participation rates, and (3) the number of participants who enter treatment as a result of the program and their status. The act deletes a required evaluation of behavioral changes of program participants, such as needle sharing and condom use, and the incidence of intravenous drug use to see if there is a change because of the program.

It also eliminates the requirement that DPH compile all information on the needle exchange programs and report to the Public Health and Appropriations committees.

EFFECTIVE DATE: October 1, 2011

§ 12 — CONTINUING EDUCATION FOR CHIROPRACTORS

By law, chiropractors applying for license renewal must participate in continuing education programs. The act specifies that, for registration periods beginning on and after October 1, 2012, DPH, in consultation with the Board of Chiropractic Examiners, must issue a list of up to five mandatory continuing education topics that are required for the two subsequent registration periods following their issuance. This list must be issued by October 1, 2011 and biennially thereafter.

EFFECTIVE DATE: October 1, 2011

§ 13 — CHILDHOOD VACCINES

It allows physician assistants and APRNs to provide certification that a student has met immunization requirements. Previously, only a physician could do this.

It allows the DPH commissioner to issue a temporary waiver to the schedule for active immunization for any vaccine for which the federal Centers for Disease Control and Prevention recognizes a nationwide supply shortage.

EFFECTIVE DATE: October 1, 2011

§§ 14 & 98 — CHILD DAY CARE SERVICES PROVIDED BY RELATIVES AND RETAIL STORES

The act specifies that child day care services provided by relatives, whether by formal or informal arrangements, are exempt from licensure. It also clarifies that care provided on a drop-in basis in retail establishments is exempt from licensure if the parents remain in the same store as the child. Prior law required the parents to be on the premises.

The act repeals other provisions on child day care services in retail stores addressing hours of operation; age of the child; notification of law enforcement in certain situations; hours of care per day; sanitary conditions; and staffing, including checks of staff names with the state child abuse registry.

OLR PUBLIC ACT SUMMARY

EFFECTIVE DATE: October 1, 2011

§ 15 — YOUTH CAMPS

The act increases the maximum civil penalty DPH may impose on those operating a youth camp without a license from \$500 to \$1,000 for a first offense and \$750 to \$1,500 for a second or subsequent offense. By law, each day of illegal operation after notice from DPH is a separate offense.

EFFECTIVE DATE: October 1, 2011

§ 16 — CHILD DAY CARE HOME AND GROUP DAY CARE HOME FEES

The act clarifies that the \$500 day care center fee and the \$250 group day care home fee must accompany an initial licensure or renewal application for such facilities or DPH cannot grant or renew the license.

EFFECTIVE DATE: October 1, 2011

§§ 17 & 46 — FAMILY DAY CARE HOMES

Assistants and Substitute Staff Members

Under the act, DPH must approve any person acting as an assistant or substitute staff member for a person or entity operating a family day care home. Applications for approval must (1) be made to the DPH commissioner on department forms, (2) contain information required by regulations, and (3) include a \$20 fee. The application form must have a notice that false statements made in the application are punishable as a class A misdemeanor (false statements in the second degree) (see Table on Penalties).

DPH, within available appropriations, must require initial applicants as family day care home assistants or substitute staff to undergo state and national criminal history records checks. Under existing law, each initial applicant or prospective employee of the home is subject to these checks, within available appropriations. The DPH commissioner must also request a check of the state child abuse registry.

The act establishes a \$15 fee for initial staff approvals or renewal of a staff approval. Approvals are issued or renewed for two-year terms. (It is unclear if these approvals are for the assistants or substitute staff mentioned above, or a different category of staff.)

Family Day Care Home License Fee

The act reduces the fee, from \$80 to \$40, for an initial or renewed four-year family day care home license.

Approval, Suspension, or Revocation

The act allows DPH to refuse to approve a person to act as an assistant or substitute staff member in a family day care home as well as suspend or revoke the approval, or take any other allowed regulatory action against the individual,

OLR PUBLIC ACT SUMMARY

for the same reasons that already apply to the family home's licensed operator and employees. This includes (1) having a felony conviction in Connecticut or another state for the use, attempted use, or threatened use of physical force against another; (2) having a criminal record here or in another state that the DPH commissioner reasonably believes makes the person unsuitable to act as an assistant or substitute staff member; or (3) failing to substantially comply with family day care regulations.

An individual whose approval is revoked must wait for one year following the revocation before applying for approval.

License suspension or revocation procedures apply when the DPH commissioner intends to suspend or revoke an approval or take any other action. The commissioner must notify the approved staff member in writing. The approved staff member, if aggrieved by the action, can apply in writing for a hearing, stating in the application the reasons he or she claims to be aggrieved. The application must be delivered to DPH within 30 days after the staff member received notification of the intended action. DPH must hold a hearing within 60 days from receiving the application and give the staff member at least 10 days' prior notice of the time and place of the hearing. The act specifies that these procedures do not apply to the denial of an initial approval.

As with a family day care licensee, an approved assistant or substitute staff member must notify DPH immediately upon learning of any conviction of the home's owner or operator or of any person residing or employed in the home who is providing care to a child receiving child day care services of a crime which affects the commissioner's discretion in licensing or approving individuals. Failure to do so can result in DPH (1) suspending or revoking the assistant or substitute staff member's approval and (2) imposing a civil penalty of \$100 per day.

EFFECTIVE DATE: October 1, 2011

§ 18 — WORKERS' COMPENSATION—"SUFFICIENT EVIDENCE"

The law requires applicants for a license or permit necessary to operate a business to present "sufficient evidence" of compliance with the workers' compensation insurance coverage requirements. The act allows applicants for DPH licenses and permits, instead of only DCP licenses and permits, to meet this requirement by providing the (1) name of the applicant's insurer; (2) policy number; and (3) effective coverage dates, certified as truthful and accurate, as an alternative to presenting a hard copy of the insurance certificate.

EFFECTIVE DATE: October 1, 2011

§§ 19 & 39 — STEM CELL RESEARCH PEER REVIEW COMMITTEE; STEM CELL RESEARCH ADVISORY COMMITTEE

The act authorizes compensation for Stem Cell Research Peer Review Committee members from the Stem Cell Research Fund for reviewing grant applications submitted by institutions. The DPH commissioner must establish the compensation in consultation with the Department of Administrative Services and

Office of Policy and Management (OPM).

The act allows the DPH commissioner to appoint a designee to serve on the Stem Cell Research Advisory Committee. The designee can also serve as its chairperson.

EFFECTIVE DATE: October 1, 2011

§§ 20 - 23 — EMERGENCY ILLNESSES AND HEALTH CONDITIONS

List of Emergency Illnesses and Health Conditions

The law requires the DPH commissioner to (1) annually issue a list of reportable diseases and reportable laboratory findings and (2) amend it as necessary. The act adds emergency illnesses and health conditions to the required listing. It defines “reportable diseases, emergency illnesses and health conditions” as the diseases, illnesses, conditions, or syndromes the DPH commissioner designates as required by law. These lists must be distributed to the state’s licensed physicians and clinical laboratories. The act requires a health care provider to report each case of an emergency illness and health condition in his or her practice to the local health director where the case occurs and to DPH within 12 hours of recognizing it. Under existing law, providers must do this in cases of reportable diseases.

Clinical Laboratories

The act requires a clinical laboratory to report each finding of any disease identified on DPH’s list of reportable laboratory findings to the department within 48 hours of its discovery. A laboratory that reports an average of over 30 findings per month must make the reports electronically in a DPH-approved format. Those reporting an average of less than 30 a month must submit the reports in writing, by telephone, or in a DPH-approved electronic format. These reports are confidential and not available for public inspection except for medical or scientific research purposes. DPH must provide a copy of all such reports to the health director where the affected person lives or, if not known, the town where the specimen originated.

The act defines “clinical laboratory” as any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological, or other examinations of human body fluids, secretions, excretions, or excised or exfoliated tissues, for (1) providing information to diagnose, prevent, or treat any human disease or impairment; (2) assessing human health; or (3) finding the presence of drugs, poisons, or other toxicological substances.

The act authorizes a local health director or his or her authorized agent, or DPH, when receiving a report of an emergency illness and health condition, to contact the reporting health care provider and then the person with the reportable finding to get the information necessary to effectively control further spread of the disease. The local health director and DPH already have this authority with regard to listed reportable diseases and laboratory findings.

Preparation of a Dead Body

The law imposes additional requirements on an embalmer or funeral director preparing a body for cremation or burial when death resulted from a listed reportable disease. The act applies these additional requirements to deaths due to a listed emergency illness and health condition.

Nonmaterial Fact Concerning Real Property

By law, a nonmaterial fact concerning real property does not have to be disclosed in a real estate transaction. The act expands the definition of “nonmaterial fact” to include an occupant of real property who has or had an emergency illness and health condition instead of only an occupant who is or has been infected with a disease on the reportable disease list.

EFFECTIVE DATE: October 1, 2011

§§ 24-25, 32, & 80 — CERTIFICATE OF NEED (CON)

The Office of Health Care Access (OHCA) division of DPH administers the CON program. Generally, a CON authorization is required when a health care facility proposes to (1) establish new facilities or services, (2) change its ownership, (3) purchase or acquire certain equipment, or (4) terminate certain services.

Filing Deadline

By law, a CON applicant must publish notice in a newspaper at least 20 days before filing the CON application that it plans to submit to the OHCA division of DPH. The act sets a deadline for actually filing the CON application of within 90 days after publishing the notice of the application. It also eliminates a requirement that OHCA publish notice of a properly filed CON application with the secretary of the state.

CON Exemption

By law, an outpatient surgical facility seeking to transfer or change ownership or control does not need a CON if OHCA determines that:

1. before the transfer or change of ownership or control, the facility was (a) owned and controlled exclusively by physicians either directly or through a limited liability company (LLC), corporation, or limited liability partnership (LLP) exclusively owned by physicians or (b) under the interim control of an estate executor or conservator pending transfer of an ownership interest or control to a physician and
2. after the ownership or control changes, physicians or physician-owned LLCs, corporations, or LLPs own and control at least a 60% interest in the facility.

The act adds to this exemption podiatrists owning and controlling an outpatient surgical facility.

OLR PUBLIC ACT SUMMARY

The act also makes technical changes to the CON law.

Termination of Certain Services by State Facilities

The act requires state hospitals and institutions to get a CON before terminating inpatient or outpatient services eligible for reimbursement under Medicare or Medicaid.

EFFECTIVE DATE: October 1, 2011, except for the provision requiring a CON to terminate certain services at state facilities, which is effective on passage.

§§ 26, 35, 36 — TECHNICAL CHANGES

These sections make technical changes.

EFFECTIVE DATE: October 1, 2011

§ 27 — OPIATE- DEPENDENCY TREATMENT

The act authorizes the DPH commissioner, in consultation with the Department of Mental Health and Addiction Services (DMHAS) commissioner, to implement policies and procedures allowing licensed health care providers with prescriptive authority to prescribe medications to treat opiate-dependent individuals in licensed free standing substance abuse facilities. This must be done in compliance with federal law. The DPH commissioner can authorize this while in the process of adopting such policies and procedures in regulation. She must print notice of the intent to adopt the regulations in the *Connecticut Law Journal* within 30 days after these policies and procedures are implemented. They remain valid until the regulations are adopted.

EFFECTIVE DATE: Upon passage

§ 28 — MATERNITY HOMES

The act removes maternity home licensing fees from DPH statutes because PA 09-197 transferred their licensing authority to the Department of Children and Families (DCF).

EFFECTIVE DATE: October 1, 2011

§ 29 — BREAST AND CERVICAL CANCER EARLY DETECTION AND TREATMENT REFERRAL PROGRAM

The act makes changes to the Breast and Cervical Cancer Early Detection and Treatment Referral Program.

Under prior law, DPH had to provide unserved or underserved populations, within existing appropriations and through contracts with health care providers, with (1) clinical breast examinations, (2) screening mammograms and pap tests, (3) a 60-day follow-up pap test for victims of sexual assault, and (4) a pap test every six months for women who have tested HIV positive. “Unserved or underserved populations” are women (1) at or below 200% of the federal poverty level, (2) without health insurance that covers breast cancer screening

OLR PUBLIC ACT SUMMARY

mammography or cervical cancer screening services, and (3) 19 to 64 years of age.

The act changes the definition of “unserved or underserved populations” by raising the minimum age from 19 to 21. It also eliminates the 60-day follow-up pap test for victims of sexual assault.

The act deletes a requirement that DPH report annually to the Public Health and Appropriations committees on the state’s rates of (1) breast cancer and cervical cancer morbidity and mortality and (2) participation in breast and cervical cancer screening.

EFFECTIVE DATE: October 1, 2011

§ 30 & 34 — EMERGENCY MEDICAL SERVICES

The act requires the DPH commissioner to annually report to the Emergency Medical Services Advisory Board instead of the Public Health Committee on the number of emergency medical services (EMS) calls received during the year; response times; level of EMS required; names of EMS providers responding; and the number of passed, cancelled, and mutual aid calls. It eliminates a requirement for DPH to (1) make the report publicly available and (2) post it on its website. It also specifies that emergency air transport services are not considered ambulance services for purposes of rate-setting by DPH.

It also removes the regional medical services coordinators from the EMS Advisory Board’s membership. PA 10-117 repealed the requirement that regional EMS councils, or the DPH commissioner in regions without a council, appoint a regional EMS coordinator.

EFFECTIVE DATE: Upon passage, except for the change to board membership, which is effective October 1, 2011.

§ 31 — OFFICE OF MULTICULTURAL HEALTH

The act eliminates the requirement that DPH annually report on the activities of the Office of Multicultural Health to the governor, General Assembly, Permanent Commission on the Status of Women, Latino and Puerto Rican Affairs Commission, Indian Affairs Council, and African-American Affairs Commission. It also eliminates the requirement that the office hold community workshops and other means to disseminate its findings.

EFFECTIVE DATE: October 1, 2011

§ 33 — LICENSED PRACTICAL NURSES

The act allows a licensed practical nurse to carry out the orders of a physician assistant, podiatrist, or optometrist as well as a physician or dentist, under the direction of a registered nurse or APRN.

EFFECTIVE DATE: Upon passage

§§ 37 & 38 — FREEDOM OF INFORMATION ACT

The act adds already confidential communications to the Freedom of

Information Act's (FOIA) list of communication and records exempt from disclosure. The communications designated by the act are those privileged by the marital, clergy-penitent, doctor-patient, or therapist-patient relationship, or any other privilege established by the common law or the general statutes. The law already exempts from disclosure records, tax returns, reports, and statements exempt under state or federal law and communications under the attorney-client privilege. The act exempts these documents and privileged communications created or made before the establishment of any of these applicable privileges under the common law or statutes.

The act also exempts from disclosure under FOIA all records obtained during an inspection, investigation, examination, and audit of a health care institution that are confidential according to a contract between DPH and the federal Department of Health and Human Services relating to Medicare and Medicaid.

EFFECTIVE DATE: October 1, 2011

§ 40 — BONE DENSITOMETRY

Beginning October 1, 2012, the act specifies that a radiographer license is not required for, nor are the activities limited of, a technologist certified by the International Society of Clinical Densitometry or the American Registry of Radiologic Technologists if the individual is operating a bone densitometry system under the supervision, control, and responsibility of a licensed physician. Under prior law, this applied to a nuclear medicine technologist certified by the Nuclear Medicine Technology Certification Board or American Registry of Radiologic Technologists.

EFFECTIVE DATE: October 1, 2011

§ 41 — DEAD BODIES FOR ANATOMICAL PURPOSES

The act adds Quinnipiac University to those institutions that have access to unclaimed bodies for use in medical study.

EFFECTIVE DATE: October 1, 2011

§§ 42, 53 & 54 — ACUPUNCTURE

Definition of Practice of Acupuncture

The act expands the scope of practice of licensed acupuncturists. It defines the "practice of acupuncture" as the system of restoring and maintaining health by classical and modern Oriental medicine principles and methods of assessing, treating, and preventing (1) diseases, disorders, and dysfunctions of the body; (2) injury; (3) pain; and (4) other conditions.

The act expands the statutory definition of the practice of acupuncture to include the (1) assessment of body function, development of a comprehensive treatment plan, and evaluation of outcomes; (2) modulation, restoration, promotion, and maintenance of normal function in and between the energetic and organ systems and bodily functions; (3) recommendation of oriental dietary principles; and (4) other practices consistent with recognized standards of the

acupuncture and Oriental medicine profession accepted by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM).

Prior law defined acupuncture as treatment by mechanical, thermal, or electrical stimulation by inserting needles or applying heat, pressure, or electrical stimulation at one or more points on the body to achieve therapeutic or prophylactic effect. The practitioner must select the points on the body based on the theory of the physiological interrelationship of body organs with an associated point for diseases, disorders, and dysfunctions of the body. It does not include physical therapy.

Development of Comprehensive Treatment Plan

Under the act, the practice of acupuncture includes the assessment of body function, development of a comprehensive treatment plan, and evaluation of treatment outcomes according to acupuncture and Oriental medicine theory.

Modulation and Restoration of Normal Body Functions

The practice of acupuncture also includes modulation and restoration of normal function in and between the body's energetic and organ systems and biochemical, metabolic, and circulation functions using certain methods. These methods include stimulation of selected points by inserting needles, including trigger point, subcutaneous, and dry needling, and other methods consistent with acupuncture and Oriental medicine professional standards.

Promotion and Maintenance of Normal Body Functions

Acupuncture also includes the promotion and maintenance of normal function in the body's energetic and organ systems and biochemical, metabolic, and circulation functions by recommending Oriental dietary principals, including using herbal and other supplements, exercise, and other self-treatment techniques according to Oriental medicine theory.

The act also makes technical and conforming changes.

Acupuncture Licensure Exception

The act, notwithstanding licensure requirements, allows DPH, by August 12, 2011, to issue an acupuncture license to an applicant who presents satisfactory evidence that he or she (1) passed the NCCAOM written exam by test or credentials review before April 28, 2010 and (2) successfully completed the (a) NCCAOM practical exam of point location skills and (b) Council of Colleges of Acupuncture and Oriental Medicine clean needle technique course on March 13, 2010.

EFFECTIVE DATE: October 1, 2011, except for the licensing exception, which is effective on passage.

§ 43 — DRUG SCREENING

The act requires DPH, in consultation with DMHAS, to allow the use of saliva-based drug screening or urinalysis when initial and subsequent drug

screenings of people abusing substances other than alcohol are conducted at DPH-licensed facilities.

EFFECTIVE DATE: October 1, 2011

§§ 44 & 97 — SCHOOL-BASED HEALTH CENTER ADVISORY COMMITTEE

The act replaces a committee on school-based health centers (SBHCs) with a new SBHC advisory committee that must help the DPH commissioner develop recommendations for statutory and regulatory changes for improving health care through access to SBHCs. The committee includes (1) the commissioners, or their designees, of public health, social services, DMHAS, and education and (2) three SBHC providers appointed by the board of directors of the Connecticut Association of School-Based Health Centers.

The committee must meet at least quarterly and report, by January 1, 2012 and annually afterwards, to the Public Health and Education committees. Administrative support for the advisory committee may be provided by the Connecticut Association of School-Based Health Centers.

EFFECTIVE DATE: Upon passage

§ 45 — FLUOROSCOPY AND PHYSICIAN ASSISTANTS

Prior law established training criteria that a physician assistant (PA) had to meet beginning October 1, 2011 in order to use fluoroscopy to guide diagnostic and treatment procedures and a mini C-arm in conjunction with it. A PA had to complete 40 hours of training that included radiation physics, radiation biology, radiation safety, and radiation management applicable to fluoroscopy. At least 10 hours had to address radiation safety, and at least 15 hours had to address radiation physics and biology. A PA also had to pass a DPH-prescribed test.

The act, instead, requires successful completion of 40 hours of didactic instruction relevant to fluoroscopy, which includes radiation biology and physics, exposure reduction, equipment operation, image evaluation, quality control, and patient consideration. It also adds a minimum of 40 hours of supervised clinical experience that includes a demonstration of patient dose reduction, occupational dose reduction, image recording, and quality control of equipment. The testing requirement remains.

Prior law permitted a PA to perform fluoroscopy and use a mini C-arm before October 1, 2011 without the training by passing the DPH exam. A PA who did not pass the test by October 1, 2011 could not use a fluoroscope or mini C-arm until he or she met the law's training and test requirements. The act extends, until July 1, 2012, the date by which a PA can continue the fluoroscopic procedures only by passing the exam. If the PA does not pass the required examination by July 1, 2012, he or she must meet the training, supervised clinical experience, and testing requirements above in order to perform these procedures.

EFFECTIVE DATE: October 1, 2011

§§ 47-49 & 73 — FUNERAL SERVICE BUSINESS; SATELLITE OFFICE

The act allows a funeral services business that has an inspection certificate to operate a single satellite office solely to meet clients to make arrangements for cremation services. No other funeral service business activities may be conducted at the satellite office. Any person, firm, partnership, or corporation seeking to add a satellite office must provide 30 days advance written notice to DPH on a form it prescribes. Any authorized satellite office must be open at all times for inspection by DPH; the department may inspect the satellite office whenever deemed advisable. All records concerning arrangements made at the satellite office must be maintained at the address of record of the funeral service business as identified on the certificate of inspection. Failure to comply with the provisions of this section may constitute grounds for disciplinary action by DPH.

(Special Act 11-17 repeals this provision and instead requires DPH to establish a pilot program that allows one funeral service business that has an inspection certificate to operate a single satellite office solely to meet with clients to make arrangements for cremation services. No other funeral service business activities may be conducted at the satellite office. It takes effect July 1, 2011.)

The act also makes technical changes concerning funeral service businesses. EFFECTIVE DATE: July 1, 2011, except for the technical changes, which are effective October 1, 2011.

§ 50 — TELEPHARMACY PILOT PROGRAM

The act authorizes the DCP commissioner, in consultation with the DPH commissioner, to establish a pilot program allowing a hospital that operates a hospital pharmacy to use electronic technology or telepharmacy at the hospital's satellite or remote locations to allow a clinical pharmacist to supervise pharmacy technicians in preparing IV admixtures.

"IV admixture" means an IV fluid to which one or more additional drug products have been added. "Electronic technology" or "telepharmacy" means the process (1) by which each step involved in the preparation of IV admixtures is verified by a bar code tracking system and documented by digital photographs that are electronically recorded and preserved and (2) which is monitored and verified through video and audio communication between a licensed supervising clinical pharmacist and a pharmacy technician.

Under the pilot program, a clinical pharmacist is authorized to supervise a pharmacy technician through electronic technology use. A supervising clinical pharmacist must monitor and verify the pharmacy technician's activities through audio and video communication. If the electronic technology malfunctions, no IV admixtures prepared by the pharmacy technician during the malfunction period can be distributed to patients unless an appropriately licensed person can (1) personally review and verify all of the processes used in preparing the IV admixture or (2) after the technology is restored, use the electronic technology mechanisms that recorded the pharmacy technician's actions to confirm that all proper steps were followed in preparing the IV admixture. All orders for medication under the pilot program must be verified by a pharmacist before delegating to a pharmacy technician for IV admixture preparation.

A hospital participating in the pilot program must ensure that appropriately

OLR PUBLIC ACT SUMMARY

licensed health care personnel administer medications at the hospital's satellite or remote locations. The act specifies that all processes involved in operating the program are under the purview of the hospital's pharmacy director.

A hospital selected for the pilot program must make periodic quality assurance evaluations which, at a minimum, include review of any error in medication administration. The hospital must make these evaluations available to DCP and DPH for their review.

The pilot program may begin as of July 1, 2011 and must end by December 31, 2012. But the DCP commissioner may terminate it earlier for good cause.

EFFECTIVE DATE: Upon passage

§ 51 — DMHAS-LEASING OF RESIDENTIAL UNITS

The act authorizes the DMHAS commissioner to represent the state in leasing residential units as part of a program of housing services for its clients if each unit is no more than 2,500 square feet. By law, DMHAS can sign a lease or other rental agreement for private housing on behalf of one of its clients. The department must first determine that the client is unable to rent or lease the residence on his or her own.

EFFECTIVE DATE: October 1, 2011

§ 52 — NURSING HOME WAITING LIST

The act allows a nursing home, without regard to its waiting list order, to admit an applicant who seeks a transfer from a nursing home in which the applicant was placed (1) following the closure of a home where he or she previously resided or (2) due to the anticipated closure of a home placed in receivership where the applicant previously resided. The transfer must occur within 60 days after the date the applicant was transferred from the previous nursing home and the applicant must have submitted an application to the nursing home to which he or she seeks admission at the time of the transfer from the previous nursing home.

EFFECTIVE DATE: October 1, 2011

§ 55 — UNIFORM LICENSING PROCESS FOR COMMUNITY-BASED PROVIDERS

The act requires a study of the feasibility of (1) establishing a uniform state licensing process for community-based providers and (2) implementing deemed status. (Certain accrediting organizations have deeming authority for federal Centers for Medicare and Medicaid (CMS) certification.) The study must be undertaken by the nonprofit liaison to the governor, in consultation with the DPH, developmental services (DDS), social services (DSS), DCF, and DMHAS commissioners or their designees; and two representatives of community-based providers selected by the governor's liaison, one recommended by the Connecticut Association of Nonprofits and the other by the Connecticut Community Providers Association.

OLR PUBLIC ACT SUMMARY

At a minimum, the study must examine whether a community-based provider may be allowed to obtain a single state license that allows it to offer services for multiple state agencies without requiring separate licenses from each state agency for which services are offered. By January 1, 2012, the nonprofit liaison must report to the Public Health and Human Services committees on the feasibility of establishing the uniform licensing process and implementing deemed status. The nonprofit liaison may include any legislative recommendations that she believes are necessary for meeting these objectives.

EFFECTIVE DATE: Upon passage

§ 56 — RESIDENTIAL CARE HOMES

Under the act, a residential care home that is colocated with a chronic and convalescent nursing home or a rest home with nursing supervision may request DPH's permission to meet Public Health Code requirements concerning attendants in residence from 10:00 p.m. to 7:00 a.m. through the use of shared personnel.

It requires a residential care home to maintain temperatures in resident rooms and all other areas used by residents at a minimum temperature of 71 degrees Fahrenheit.

A residential care home must ensure that the maximum time between a resident's evening meal and breakfast does not exceed 14 hours unless a substantial bedtime nourishment is offered by the home.

Beginning July 1, 2011, DPH can no longer (1) require that a person seeking a license to operate a residential care home supply to the department a certificate of physical and mental health, signed by a physician, at the time of an initial or subsequent application for licensure and (2) approve the time scheduling of regular meals and snacks in residential care homes.

The act directs the DPH commissioner to amend the Public Health Code to conform with these provisions.

EFFECTIVE DATE: July 1, 2011

§ 57 — DISCLOSURE OF CHILD ABUSE AND NEGLECT INFORMATION BY DCF TO DPH

The act revises the information DCF must report to DPH about child abuse or neglect (1) occurring in a day care center, group day care home, family day care home, or DPH-licensed youth camp or (2) involving a facility's license holder, any facility staff, or any household member of a family day care home, regardless of where the abuse or neglect occurred.

It eliminates the requirement that DCF provide all records of reports and investigations of suspected abuse or neglect, including records of any administrative hearings it holds. It instead requires DCF to provide such records only for reports and investigations of child abuse or neglect that have been reported to or are being investigated by DCF.

The act also revises the information DPH must keep on its corresponding abuse and neglect list. By law, DPH must keep a list of violations it substantiated

OLR PUBLIC ACT SUMMARY

during the previous three years concerning these facilities and disclose the information on the list, with certain exceptions, upon request. The act specifies that the information may be disclosed only if allowed by law. Information identifying children or their family members continues to be confidential.

It allows DPH to include on this list DCF reports of recommended findings of child abuse or neglect at a facility, instead of suspected abuse or neglect at a facility, that resulted or involved (1) a child's death, (2) serious physical harm or the risk of serious physical injury or emotional harm to a child, (3) child sexual abuse, (4) a person's arrest for child abuse or neglect, or (5) DCF petitioning to commit a child to its care or terminate a parent's rights to the child.

By law, if DCF subsequently notifies DPH that its (1) investigation did not substantiate the abuse or neglect or (2) finding was reversed after appeal, DPH must immediately remove the information from its list and stop disclosing it. The act makes conforming changes and specifies that DCF must immediately provide DPH with this information.

The act also makes technical changes.

EFFECTIVE DATE: October 1, 2011

§§ 58 & 59 — WATER RESOURCES LIST; STATE PLAN OF CONSERVATION AND DEVELOPMENT

By October 31, 2011, the act requires the DPH commissioner to consult with the Water Planning Council and prepare a list designating actual or potential water sources that need protection to ensure the highest quality water sources are available for human consumption. In preparing the list, the commissioner must consider the following plans:

1. the statewide long-range water resource plan;
2. water supply plans submitted to DPH by certain water companies;
3. coordinated water system plans biennially reported to DPH by each public water supply management area's water utility coordinating committee; and
4. any other plans or information she deems relevant.

The commissioner must update the list at least annually, but may do so as frequently as she deems necessary. The act specifies that it does not limit the commissioner's authority to approve a water supply source not on the list.

The act also requires the Office of Policy and Management (OPM) to consider (1) state water supply and resource policies and (2) the above water resources list, when revising the State Plan of Conservation and Development after December 1, 2011.

EFFECTIVE DATE: Upon passage

§§ 60 - 68 — BOTTLED WATER AND NONALCOHOLIC BEVERAGES

Approved Water Sources

The act requires DPH to inspect and approve only in-state sources of water bottled for sale or distribution, instead of all sources. If the in-state source meets federal quality and safety requirements, DPH must issue a three-year approval.

It requires water bottlers using an out-of-state source to submit to the DCP

commissioner a copy of a current license or approval for the source's use from each government entity having regulatory jurisdiction. The bottler must do this when (1) applying or reapplying for a bottled beverage license from DCP, (2) the source or source treatment is substantially modified, or (3) a new source is added.

Prior law required all bottled water sold and distributed in Connecticut to comply with contaminant and action levels and monitoring procedures DPH established for public drinking water. The act, instead, requires all bottled water to comply with the federal Food and Drug Administration's (FDA) quality standards.

Licensure Requirements—Nonalcoholic Beverages

The law requires an annual license from DCP to sell beverages bottled or manufactured out-of-state. The act expands the licensure requirement to distribution of these beverages. The license application fee is \$150.

The law exempts out-of-state manufacturers, bottlers, and distributors of malt and cereal drinks; grape and lime juice; fruit-flavored syrups, powders or mixtures; concentrated fruit juices; or fruit and vegetable juices from the licensure requirement.

License Revocation and Suspension—Water Bottlers

Prior law allowed the DCP commissioner to suspend or revoke the license of a water bottler who failed to use a DPH-approved source. The act instead allows her to do this only for water bottled from a Connecticut source. It also allows the commissioner to take such action if the water bottler uses an out-of-state source not approved by the government entities having regulatory jurisdiction over its use.

Source Testing

The law requires water bottlers, among other things, to collect samples from each approved source at least once a year to test for regulated contaminants and at least one every three years for unregulated contaminants. A DPH-approved laboratory must analyze the samples to determine compliance with microbial standards established by DPH for public drinking water. The laboratory must also conduct tests at least once every three months if the source is not a public water supply.

The act requires these water samples to comply with federal FDA microbial standards instead of those established by DPH. It also allows bottlers to use a U.S. Environmental Protection Agency (EPA)-certified laboratory to conduct the testing in addition to a DPH-registered laboratory.

Product Testing

Prior law required water bottlers to collect a sample of their bottled product at least once per week and a DPH approved laboratory to analyze it for compliance with DPH-established microbial standards. It also had to analyze a sample at least annually for compliance with chemical, physical, and radiological regulations.

OLR PUBLIC ACT SUMMARY

The act, instead, requires these samples to comply with federal FDA standards and allows the use of an EPA-certified laboratory to conduct the testing.

It allows bottlers using an out-of-state source to meet these testing requirements by demonstrating compliance with substantially similar standards established by the government entity having regulatory jurisdiction over the source.

The act also requires water bottling lines and equipment to comply with federal FDA standards rather than DPH regulations.

Reporting Testing Results

The act requires (1) the above laboratory results to be available only to DCP, instead of both DCP and DPH and (2) water bottlers to report only to DCP, instead of both DCP and DPH, any laboratory results indicating contamination in amounts exceeding applicable standards within 24 hours.

It also makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2011

§ 69 — CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY FOR WATER COMPANIES

The law requires certain water companies to get a certificate of public convenience and necessity from the Department of Public Utility Control (DPUC) and DPH before they begin constructing and expanding their systems. The act adds two conditions under which DPUC and DPH must issue these certificates: (1) the proposed water supply system will not adversely affect the adequacy of nearby water systems and (2) any existing or potential pollution threat DPH deems to be adverse to public health will not affect any new water supply source.

The law requires the departments to issue a certificate if they find that:

1. no interconnection is feasible with a water system owned by, or made available through an arrangement with, the provider of the exclusive service area (ESA) or with another existing water system where no ESA has been assigned;
2. the applicant plans to build or expand according to DPUC-established engineering standards;
3. ownership of the system will be assigned to the ESA provider under certain circumstances;
4. the system's owner has the financial, technical, and managerial resources to operate the proposed water supply system reliably and efficiently enough to provide continuous service;
5. the proposed construction or expansion would not result in a duplication of service in the applicable service area; and
6. the system meets all federal and state standards for water supply systems.

EFFECTIVE DATE: October 1, 2011

§ 70 — ABANDONING WATER SOURCES

By law, any entity seeking to abandon a water source must apply to the DPH

commissioner for an abandonment permit. The act requires the entity, 30 days before filing an application, to notify the local health department or district in each town in which the water supply source is located. The law already (1) requires the entity to notify each town's chief elected official and (2) permits towns and other water companies to submit comments to the commissioner within 60 days of receiving notice from the company. The act extends this comment opportunity to local health departments or districts. The commissioner must consider these comments in deciding whether to grant a permit.

In making her decision about abandoning a water supply source, the law requires the commissioner to consider (1) the water company's and the state's water supply needs and (2) any comments she received about the application. She must also consult with the environmental protection commissioner, the OPM secretary, and DPUC.

The act specifies that the commissioner need not consult with these agencies if she determines the proposed abandoned water supply source is (1) a groundwater source with a safe yield of less than 10 gallons per minute and (2) of poor water quality. The law defines "safe yield" as the maximum dependable quantity of water per unit of time that may flow or be continuously pumped from a supply source during a critical dry period without consideration of available water limitations.

EFFECTIVE DATE: October 1, 2011

§ 71 — SMALL WATER SYSTEM, TREATMENT PLANTS, AND DISTRIBUTION SYSTEM CERTIFICATION

Certification Required

The act requires DPH to certify small water systems that (1) treat or supply water for public use, (2) test backflow prevention devices, or (3) perform cross-connection surveys. DPH must already do this for water treatment plants and water distribution systems that perform these functions. It requires DPH to adopt regulations on standards and procedures for issuing and renewing certificates for small water systems as it must already do for water treatment plants and water distribution systems.

Under the act, a "small water system" serves fewer than 1,000 people and has either (1) no treatment or (2) treatment that does not require any chemical treatment, process adjustment, backwashing, or media regeneration by an operator.

Fees

The act authorizes the commissioner to issue an initial three-year certificate for these small water systems, treatment plants, and distribution system activities and establishes certification fees. An entity must submit a completed application in a form the commissioner prescribes and an application fee as follows:

1. \$224 for a water treatment plant, water distribution system, or small water operator certificate and
2. \$154 for a backflow prevention device tester certificate or cross-connection

survey inspector certificate.

Certificates may be renewed for an additional three years if the certificate holder completes a renewal application and pays the following renewal fees:

1. \$98 for a water treatment plant, water distribution system, or small water operator certificate and
2. \$69 for a backflow prevention device tester certificate or cross-connection survey inspector certificate.

EFFECTIVE DATE: July 1, 2011

§ 72 — PRIVATE RESIDENTIAL WELLS

Testing and Reporting

The act requires a laboratory or firm testing a private residential well to report the results to DPH, instead of only the local health authority, in a format the department specifies. Results must be reported within 30 days, if the test is performed within six months of the property's sale. Otherwise no report is required.

The act requires a property owner, before selling, exchanging, purchasing, transferring, or renting property with a residential well, to notify the buyer or tenant that educational material concerning residential well testing is available on the DPH website. It specifies that failure to provide the notice does not invalidate the property transaction. If the seller or landlord provides written notification, he or she and any real estate licensee are deemed to have satisfied the notification requirement.

The act specifies that a laboratory or firm is a DPH-registered environmental laboratory.

DPH Regulations

Prior law prohibited DPH from adopting certain regulations affecting the testing of private residential wells. The act eliminates provisions barring the testing of a private residential well for:

1. alachlor, atrazine, dicamba, ethylene dibromide, metolachlor, simazine or 2,4-d, or any other herbicide or insecticide unless (a) a prior test showed a nitrate concentration of at least 10 milligrams per liter and (b) the local health director had reasonable grounds to suspect the presence of such chemicals and
2. organic chemicals unless a local health director had reasonable grounds to suspect their presence.

It instead allows a local health director to require private residential well testing for (1) radionuclides and (2) pesticides, herbicides, or organic chemicals when there are reasonable grounds to suspect the presence of such contaminants in the groundwater.

The act defines "reasonable grounds" as:

1. for radionuclides, (a) the existence of a geological area known to have naturally occurring radionuclide deposits in the bedrock or (b) when the well is located in an area known to have radionuclides in the groundwater

and

2. for pesticides, herbicides, or organic chemicals, (a) the presence of a nitrate-nitrogen groundwater concentration of at least 10 milligrams per liter or (b) when the well is located on or in proximity to land associated with past or present production, storage, use, or disposal of organic chemicals as identified in any public record.

Sample Collections

The act allows private residential well samples to determine water quality to be collected only by (1) employees of a DPH-certified or -approved laboratory who are trained in sample collection techniques, (2) certified water operators, (3) local health departments and state employees trained in sample collection techniques, or (4) individuals with training and experience DPH deems as sufficient.

The act creates an exception to this requirement for qualified homeowners or general contractors. Prior law allowed homeowners and general contractors of new residential construction, where private residential wells are located, to collect water samples for testing by a laboratory or firm, if the laboratory or firm found that the owner or contractor was qualified to collect the sample. The act continues to allow such sample collection if the (1) laboratory or firm provides instructions to the owner or general contractor on how to collect the samples and (2) owner or general contractor is identified to the subsequent owner on a DPH-prescribed form.

EFFECTIVE DATE: October 1, 2011

§ 74 — HEALTH INFORMATION TECHNOLOGY

The act requires the Health Information Technology Exchange of Connecticut's board of directors to establish an advisory committee on patient privacy and security. The board's chairman appoints the members, who must have expertise in the field of privacy, health data security, or patient rights. Advisory committee members must include a representative from a nonprofit research and educational organization dedicated to improving access to health care and a patient advocacy group; an ethicist; an attorney with expertise in health information technology and Health Insurance Portability and Accountability Act protections; the chief information officer of a hospital; an insurer or representative of a health plan; and a primary care physician in active practice who uses electronic health records. The lieutenant governor appoints the committee chairperson.

The committee must monitor developments in federal law concerning patient privacy and security relating to health information technology and report to the board on national and regional trends and federal policies and guidance. The board must include information supplied by the advisory committee in the annual report it makes to the legislature and the governor.

EFFECTIVE DATE: July 1, 2011

§ 75 — DENTIST LICENSURE FOR GRADUATES OF FOREIGN DENTAL SCHOOLS

By law, DPH can issue a dental license to an applicant who is a graduate of a foreign dental school if he or she meets certain requirements. One of these is successful completion, at a level greater than the second postgraduate year, of at least two years of an accredited residency or fellowship training program in a community or school-based health center affiliated with and under the supervision of a dental school in this state. The act increases this to three years of a residency or fellowship training program in a dental school in the state but no longer requires it to be served in a community or school-based health center.

EFFECTIVE DATE: July 1, 2011

§ 76 — CHILD DAY CARE INVESTIGATIONS BY DPH

The act authorizes DPH to administer oaths, issue subpoenas, compel testimony, and order the production of books, records, and documents in any investigation concerning (1) an application for or reinstatement or renewal of a child day care center, group day care home, or family day care home license; (2) a complaint about child day care services; or (3) the possible provision of unlicensed child day care services.

The act authorizes a Superior Court judge to make appropriate orders to help enforce these provisions if a person refuses to appear, testify, or produce any book, record, or document as ordered by DPH.

EFFECTIVE DATE: October 1, 2011

§ 77 — APRN LICENSURE

The act modifies one of the criteria for licensure as an APRN by substituting a “graduate” degree for a “master’s degree.” Previously, if an APRN license applicant was first certified by one of the statutorily listed national bodies after December 31, 1994, he or she was required to hold a master’s degree in nursing or in a related field recognized for certification as either a nurse practitioner, a clinical nurse specialist, or a nurse anesthetist.

EFFECTIVE DATE: October 1, 2011

§ 78 — STANDING ORDERS

PA 11-2 allows hospitals to use standing orders to treat patients under certain conditions. This act changes this provision’s effective date from October 1, 2011 to July 1, 2011.

EFFECTIVE DATE: Upon passage

§ 79 — PATIENT ACCESS TO MEDICAL TEST RESULTS

The act (1) requires clinical laboratories to provide patient test results to additional health care providers in certain situations and (2) allows a patient to receive test results directly when the patient is undergoing repeated testing. DPH

must adopt regulations to implement the act.

The law requires a health care provider, except in limited circumstances, to give patients who ask, complete and current information the provider has about their diagnosis or treatment. The provider must also notify a patient of any test results in his or her possession or requested by the provider for purposes of diagnosis, treatment, or prognosis. The law generally does not allow direct reporting to patients of laboratory test results. But they may be reported to patients upon the written request of the provider who ordered the testing (Conn. Agencies Reg. § 19a-36-D32).

Test Results to Additional Providers

Under the act, if a patient or a provider who orders medical tests for the patient asks, a clinical laboratory must supply the test results to any other provider who is seeing the patient for treatment, diagnosis, or prognosis. For the purposes of the act, a clinical laboratory does not include any state laboratory established by DPH.

Direct Reporting to Patient

Under the act, a provider can issue a single authorization allowing a clinical laboratory or other entity performing medical testing to give the test results directly to the patient in situations where the provider asks the patient to submit to repeated testing at regular intervals over a specified time period. Such testing must be for determining a diagnosis, prognosis, or recommended treatment course.

EFFECTIVE DATE: October 1, 2011

§§ 81 & 82 — CHILDHOOD VACCINES

Under the act, beginning October 1, 2011, one group health care provider located in Bridgeport and one in New Haven, as identified by the DPH commissioner, and any health care provider in Hartford who administers vaccines to children under the federal Vaccines For Children (VFC) program (operated by DPH under federal authority, 42 USC § 1396s) may choose under the federal program any vaccine the federal Food and Drug Administration (FDA) licenses, including any combination vaccine and dosage form, if it is (1) recommended by the National Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices and (2) made available to the department by CDC. DPH must provide the vaccine.

VFC is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. VFC is required as part of each state's Medicaid plan. VFC pays for any brand of vaccine that CDC recommends.

By June 1, 2012, the DPH commissioner must provide the Public Health Committee with an evaluation of the vaccine program established above. The evaluation must include an assessment of the program's effect on child immunization rates, an assessment of any health or safety risks the program poses,

and recommendations regarding future program expansion.

Under the act, if the program evaluation does not show a significant reduction in child immunization rates or an increased risk to the health and safety of children, then beginning July 1, 2012, any health care provider who administers vaccines to children under the VFC program may select, and DPH must provide, any vaccine licensed by the FDA, including any combination vaccine and dosage form, that is (1) recommended by the CDC Advisory Committee on Immunization Practices and (2) made available to the department by the CDC.

The act specifies that these provisions expanding vaccine choices do not apply in the event of a public health emergency, attack, major disaster, emergency, or disaster emergency as defined in law.

EFFECTIVE DATE: July 1, 2011

§§ 83 & 84 — STRATEGIC PLAN FOR LONG-TERM CARE REBALANCING AND CON MORATORIUM EXEMPTION

Strategic Plan

The act requires the DSS commissioner to develop a strategic plan, consistent with the state's long-term care plan, to rebalance Medicaid long-term care supports and services, including supports and services provided in-home, in a community-based setting, and in institutions. He must include providers from all three setting types in the development of the plan.

In developing the plan, the commissioner must consider topics that include:

1. regional trends concerning the state's aging population,
2. trends in the demand for long-term care services,
3. gaps in the provision of home- and community-based services that prevent community placements,
4. gaps in the provision of institutional care,
5. the quality of care providers in all three settings offer,
6. the condition of institutional buildings,
7. the state's regional supply of institutional beds,
8. the current rate structure applicable to long-term care services (it appears this means Medicaid rates),
9. methods of implementing adjustments to the bed capacity of individual nursing homes, and
10. a review of the nursing home CON moratorium.

The act permits the DSS commissioner to contract with nursing homes and home- and community-based providers to carry out the plan. It also permits him to revise a rate paid to a nursing home to carry out the plan. The act authorizes the commissioner to fund plan initiatives with federal grants available under the Money Follows the Person Demonstration Program and the State Balancing Incentive Payment Program provisions in federal law.

The act permits the DPH commissioner or her designee to waive certain provisions in the Public Health Code regulating nursing homes, residential care homes, and assisted living service agencies if (1) a regulated provider requires it to carry out the strategic plan and (2) the commissioner or her designee

determines that the waiver will not endanger the provider's residents' or clients' health or safety. The act permits the commissioner or her designee to impose conditions on granting the waiver that may be necessary to ensure the residents and clients' health and safety and allows her to revoke the waiver on a finding of health or safety being jeopardized.

CON Moratorium

The act exempts from the general CON moratorium on new nursing home beds those beds that are relocated to a new facility to meet a priority need identified in the strategic plan. By law, the moratorium is due to expire on June 30, 2012.

EFFECTIVE DATE: July 1, 2011

§ 85 — HEALTH CARE INSTITUTIONS-DPH DISCIPLINARY AUTHORITY

The act authorizes DPH to impose a directed plan of correction on a health care institution when she finds that there has been a substantial failure by the institution to comply with statutory or regulatory requirements, including licensing regulations.

EFFECTIVE DATE: October 1, 2011

§§ 86-89 — HOSPITAL ASSESSMENTS

Late Fees and Assessments

By law, hospitals are assessed for OHCA's costs. Previously, failure to pay an assessment on time resulted in a late fee of \$10 and interest at the rate of 1.25% per month or fraction thereof on the assessment and late fee. "Hospital" means one licensed by DPH as a short-term acute-care general hospital, children's hospital, or both.

The act, instead, requires the DPH commissioner to impose a fee equal to (1) 2% of the assessment if failure to pay is for five days or less, (2) 5% of the assessment if failure to pay is for more than five days but not more than 15 days, or (3) 10% of the assessment if failure to pay is for more than 15 days. If a hospital fails to pay any assessment for more than 30 days after the date due, the commissioner may, in addition to these fees, impose a civil penalty of up to \$1,000 for each day past the initial 30 days that the assessment is not paid.

Any civil penalty must be imposed according to law, which requires notification by first-class mail or personal service and must include (1) a reference to the sections of the statute or regulation involved, (2) a short and plain statement of the matters asserted or charged, (3) a statement of the amount of the civil penalty or penalties to be imposed, (4) the initial date of the imposition of the penalty, and (5) a statement of the party's right to a hearing. The party can request a hearing and appeal a DPH ruling.

Electronic Funds Transfer

Under the act, DPH can require a hospital to pay the assessment by an

approved method of electronic funds transfer (EFT). A hospital making an EFT must initiate the transfer in time to ensure that a bank account designated by the department is credited by EFT for the assessment amount required by the date the assessment is due.

Where an assessment is required to be made by EFT, any payment made by any other method and any payment made by EFT, where the bank account designated by DPH is not credited for the amount of the assessment by the due date, must be treated as an assessment not made in time. Any assessment treated as not timely because it was not made by EFT is subject to a penalty equal to 10% of the assessment required to be made by EFT.

Where an assessment made by EFT is treated as an assessment not timely made because the bank account designated by the department is not credited by EFT for the amount of the assessment by the due date, a penalty is imposed equal to (1) 2% of the assessment required to be made by EFT, if the failure to pay is five days or less; (2) 5% of the assessment required to be made if failure to pay is for more than five days but not more than 15 days; or (3) 10% of the assessment, if the failure to pay is for more than 15 days.

DPH must deposit all payments received with the state treasurer to be credited to the General Fund and accounted for as expenses recovered from hospitals.

EFFECTIVE DATE: July 1, 2011

§ 90 — CRIMINAL HISTORY AND PATIENT ABUSE BACKGROUND SEARCH PROGRAM

The act requires long-term care facilities to ensure that potential service providers undergo criminal history and patient abuse background searches before they are allowed direct access to patients or residents. It requires DPH to establish, within available appropriations, a program to facilitate the searches, receive criminal history record check results from the Department of Public Safety (DPS), and notify facilities of people with disqualifying offenses.

The act defines “criminal history and patient abuse background search” or “background search” as (1) state and national criminal history record checks conducted in accordance with state law, (2) a review of DPH's nurse's aide registry, and (3) a review of any other registry that DPH specifies and deems necessary for administering a background search program.

It requires the DPH commissioner to adopt implementing regulations. It allows the department to implement policies and procedures to establish the program while in the process of adopting them as regulation. She must publish notice of intent to adopt the regulations in the *Connecticut Law Journal* within 20 days of implementation. These policies and procedures are valid until the final regulations are adopted. The act also makes technical changes.

Implementation Plan

DPH must develop a plan to implement the background search program. In doing so, the department must:

1. evaluate factors including the (a) administrative and fiscal impact of

- program components on state agencies and long-term care facilities, (b) procedures currently used by long-term care facilities, (c) federal requirements under the federal Affordable Care Act (i.e., health care reform law), and (d) effect of full and provisional pardons on employment;
2. outline (a) an integrated process with DPS to cross-check and periodically update criminal information collected in criminal databases, (b) a process allowing individuals with disqualifying offenses to apply for a waiver, and (c) the structure of an internet-based portal to streamline the background search program; and
3. consult with the commissioners of Emergency Services and Public Protection, DDS, DMHAS, DSS, and DCP or their designees; the state Long-Term Care Ombudsman and Board of Pardons and Paroles chairperson or their designees; representatives of each type of long-term care facility; and any other agency or organization representatives the DPH commissioner deems appropriate.

By February 12, 2012, DPH must submit the plan, including recommendations on whether to include homemaker-companion agencies in the program's scope, to the Aging, Appropriations, and Public Health committees.

Criminal History Record and Background Check Requirement

With one exception, before offering a paid or volunteer job to, or contracting for, long-term care services with anyone who will have direct access to a patient or resident of the facility, a long-term care facility must require the person to submit to a background search.

The facility does not have to require a search if the person provides evidence that a background search carried out no more than three years immediately preceding the application date for the paid or volunteer position or contract with the facility revealed no disqualifying offense.

DPH must prescribe how (1) a facility must review the registries, including requiring the facility to report the review results to DPH, and (2) individuals must submit to state and national criminal history record checks, including requiring DPS to report the results of such checks to DPH.

Criminal History and Patient Abuse Background Search Program

By July 1, 2012, the act requires DPH, within available appropriations, to create and implement a criminal history and patient abuse background search program to facilitate the performance, processing, and analysis of background searches on people who have direct access to patients or residents of long-term care facilities.

The act defines a "long-term care facility," as a home health agency, an assisted living services agency, an intermediate care facility for the mentally retarded as defined in federal law, a chronic disease hospital, a DPH-licensed or federally certified agency providing hospice care, or a nursing home as defined in state law. (State law does not define nursing home, but it defines a "nursing home facility" as a nursing home or residential care home.)

"Direct access" means physical access to a patient or resident of a long-term

care facility that gives the provider an opportunity to commit abuse or neglect or misappropriate the patient's or resident's property.

Disqualifying Offenses and Waivers

The act requires DPH to review the criminal history record reports that DPS provides and the results of the registry reviews provided by the facilities. If a report shows that an individual has a disqualifying offense, DPH must notify the individual and long-term care facility of the disqualifying offense and of the individual's opportunity to file a written request for a waiver that would allow him or her to be employed by, or volunteer or enter into contract with, a long-term care facility.

The act defines a "disqualifying offense" as a (1) substantiated finding of neglect, abuse, or misappropriation of property by a state or federal agency under an investigation conducted in accordance with federal Medicare and Medicaid laws or (2) conviction for:

1. state or federal crimes of patient neglect or abuse in connection with the delivery of a health care item or service,
2. a federal crime related to the delivery of an item or service pertaining to the Medicare program or any state health care program receiving certain federal funds (e. g., Medicaid), or
3. any state or federal felony relating to health care fraud or controlled substances committed after August 21, 1996.

Waivers

Under the act, an individual has up to 30 days after DPH mails a notice of disqualification to file a waiver request. DPH has up to 15 business days after receiving the request to mail a written determination indicating whether it will grant the request. The 15-day deadline does not apply to instances in which an individual challenges the accuracy of the information obtained from the background search. DPH may grant a waiver to an individual who identifies mitigating circumstances surrounding the disqualifying offense, including:

1. inaccuracy in the information obtained,
2. lack of a relationship between the disqualifying offense and the position for which the individual has applied,
3. evidence that the individual has pursued or achieved rehabilitation with regard to the disqualifying offense, or
4. that substantial time has elapsed since the individual committed the disqualifying offense.

DPH and its employees are immune from civil or criminal liability that might otherwise be incurred or imposed for good faith conduct in granting waivers.

Notification of Facility

After DPH reviews the background check and patient abuse reports, it must notify, in writing, the long-term care facility to which the individual applied to get a job, volunteer, or contract whether (1) the report contains any disqualifying

offense, (2) the individual provided any information about mitigating circumstances surrounding the offense or a lack of a disqualifying offense, and (3) DPH granted a waiver.

If DPH notifies a facility that a person covered by the act has a disqualifying offense and has not received a DPH waiver, the facility cannot allow the person to work or volunteer at or contract with the facility. And if DPH grants a waiver, the act allows but does not require a facility to employ, allow to volunteer, or enter into a contract with an individual granted a waiver. The provisions apply notwithstanding state law that generally forbids the state and its agencies (except for law enforcement agencies) from denying felons employment, occupational licenses, or permission to engage in state-regulated professions without examining the (1) relationship between the crime committed and the job or license for which the person is being considered, (2) convicted person's degree of rehabilitation, and (3) time elapsed since conviction or release (CGS § 46a-80).

The act prohibits a facility from hiring (for a paid or volunteer position) or entering into a contract with an individual required to undergo a background search until it receives the DPH notification. But the facility may allow the person to work or volunteer at or contract with the facility on a conditional basis before it receives DPH notification if:

1. the conditional employment, contractual, or volunteer period lasts no more than 60 days;
2. the facility has begun the required review and the individual has submitted to the required checks;
3. the individual is subject to direct, on-site supervision; and
4. the individual affirms in a signed statement that he or she (a) has not committed a disqualifying offense and (b) acknowledges that a disqualifying offense reported in the background search constitutes good cause for termination and that a facility may terminate him or her on this ground.

Program Implementation

DPH may phase in implementation of the criminal history and patient abuse background search program by type of long-term care facility. No long-term care facility is required to comply with program provisions until the date the DPH commissioner publishes notice in the *Connecticut Law Journal* indicating that she is implementing the program for the facility type.

EFFECTIVE DATE: January 1, 2012

§§ 91-94 — CRIMINAL BACKGROUND CHECKS FOR HOMEMAKER COMPANION AGENCIES

Applicant Criminal History Record Checks

Beginning January 1, 2012, the act requires any person applying to the DCP for a homemaker-companion agency registration certificate to submit to state and national criminal history record checks. By law, these checks must be requested through the State Police Bureau of Identification.

Registration Issuance and Denial Procedures

The act adds a condition under which the DCP commissioner may revoke, suspend, or deny certificates; place registrants on probation; or issue letters of reprimand. The condition is that the homemaker companion agency failed to perform a comprehensive background check of a prospective employee or maintain a copy of material obtained during the background check. Existing law allows the commissioner to take any of these actions for (1) agency conduct (or that of an employee in the course of employment) likely to mislead, deceive, or defraud the public or the commissioner or (2) untruthful or misleading advertising.

Employee Background Checks

Prior law required a homemaker-companion agency to require an employee to submit to a comprehensive background check. Under the act, the agency must, instead, require this of any prospective employee, before offering a job or entering into a contract.

The act also requires prospective employees, instead of those already hired, to complete and sign a form containing questions about whether they were (1) convicted of a crime involving violence or dishonesty in any state or federal court or (2) subject to any decision imposing disciplinary action by a licensing agency in any state, the District of Columbia, a U.S. possession or territory, or a foreign jurisdiction. If a prospective employee makes a false written statement about his or her prior disciplinary action, he or she is guilty of a class A misdemeanor (see Table on Penalties).

The act requires each agency to keep a paper or electronic copy of any material obtained during the comprehensive background check and make them available to DCP upon request.

Definitions

The act defines a “comprehensive background check” as a background investigation performed by a homemaker-companion agency that includes:

1. a review of the applicant's employment application;
2. an in-person interview of the applicant;
3. verification of the applicant's Social Security number;
4. if the position requires the applicant's licensure, verification that the required license is in good standing;
5. a check of the DPS sex offender registry;
6. a review of criminal conviction information obtained through an in-state public records search based on the applicant's name and date of birth;
7. if the applicant has lived in the state less than three years before the employment application date, a review of criminal conviction information in any state where the applicant lived during this three-year period; and
8. a review of any additional information the agency deems necessary to evaluate the applicant's suitability for the position.

Prior law did not define “comprehensive background check,” specify

particular procedures, or identify who must conduct these checks.

The act also expands the definition of “homemaker companion agency” to include registries. It defines a “registry” as any person or entity engaged in the business of supplying or referring an individual to, or placing an individual with, a consumer to provide homemaker or companion services when the individual providing the services is either (1) directly compensated, in whole or in part, by the consumer or (2) treated, referred to, or considered by the supplying person or entity as an independent contractor. Thus a “registry” is subject to the licensing and employee background check procedures.

EFFECTIVE DATE: January 1, 2012

§ 95 — CRIMINAL BACKGROUND CHECKS FOR HOME HEALTH AGENCIES

Starting January 1, 2012, the act requires a home health agency to require employment applicants, before offering a job or entering into a contract, to submit to a comprehensive background check. It also requires these applicants to complete and sign a form containing questions about whether they were subject to any decision imposing disciplinary action by a licensing agency in any state, the District of Columbia, a U.S. possession or territory, or a foreign jurisdiction. If an applicant makes a false written statement about his or her prior disciplinary action with intent to mislead, he or she is guilty of a class A misdemeanor (see Table on Penalties). (“Comprehensive background check” has the meaning as described above.)

The act specifies that these background check requirements are valid only until the date the DPH commissioner publishes notice in the *Connecticut Law Journal* of implementation of the criminal history and patient abuse background search program for home health agencies (see above).

EFFECTIVE DATE: January 1, 2012

§ 96 — CHIROPRACTORS

The act removes the requirement that a licensed chiropractor practice only under the name of the chiropractor owning the practice or a corporate name containing the chiropractor’s name, thereby allowing the chiropractor greater flexibility in selecting a business name. It retains the existing requirement that a licensed chiropractor display his or her name on the entrance of the business or on his or her office door.

It prohibits DPH from initiating disciplinary action against a licensed chiropractor, who before July 1, 2011, is alleged to have practiced as a chiropractor under any name other than the name of the chiropractor actually owning the practice or a corporate name containing the chiropractor’s name.

EFFECTIVE DATE: July 1, 2011

§ 98 — STATEWIDE ADOLESCENT HEALTH COUNCIL

The act repeals the Statewide Adolescent Health Council.

OLR PUBLIC ACT SUMMARY

EFFECTIVE DATE: October 1, 2011

OLR Tracking: JK/ND/RC:CR:JL:ts